Sample 837 Scenarios

The sample scenarios are for test and education purposes. The information is test data and does not represent actual insurance carriers, employers, injured employees, or health care providers. The information may appear to be real or confidential information. However, this is done in order to ensure the test data passes validation edits.

TX 837 - Scenario 2

Ambulatory Surgical Center Bill (CMS-1500)

Darlene Davidson is a single female, born on 06/04/69. She lives at 5720 Green Drive in Dallas, TX 72309. Her telephone number is (214) 836-5527 and SSN is 224-17-3272.

Darlene works at Bagels, Etc. located at 234 Main Street in Dallas, TX 72314. Bagels, Etc.'s telephone number is (214) 472-1462 and their FEIN is 59-7654321.

Bagels, Etc. is covered under policy number 147643A472 by Texas Insurance Company, located at 789 Airport Road in Austin. TX 60606-1234. Texas Insurance Company's telephone number is (312) 555-1470 and its FEIN is 98-7654321.

- On 09/18/02 Darlene injured her left wrist on the job.
- Her treating doctor, Dr. David Jones, D.O. provided conservative treatment for one year until 08/27/03 when she went to Gonzo's Ambulatory Surgical Center for surgery to her left wrist.
- The surgery was performed by the surgeon, Dr. Lance Brown, license number DOG1023TX, and included neurolysis of the median nerve in her left carpal canal.

- On 09/03/03 Gonzo's ASC, located at 16 Butterfly Lane, El Paso, TX 77702, submitted a bill to the Texas Insurance Company for the total charged amount of $8,310.00.
    - 8/27/03, 64721, $3,250.00
    - 8/27/03, 01810, $5,025.00
    - 8/27/03, 94799, $35.00

- On 09/06/03 Texas Insurance Company received the bill
- On 09/10/03 a payment of $7310.00 was made. Texas Insurance Company's claim number for Darlene is 22345Z.
    - 8/27/03, 64721, $2,250.00 with ARC 45
    - 8/27/03, 01810, $5,025.00
    - 8/27/03, 94799, $35.00

Texas Insurance Company is required to report all medical bill payment information to the Texas Workers' Compensation Commission (TWCC). Texas Insurance Company is located at 100 North River Drive, San Angelo, TX 75234. Their FEIN is 76-5332244.

- On 09/15/03 Texas Insurance Company sent a transaction to TWCC covering a reporting period of 08/02/03 – 09/15/03. The unique bill id number assigned by Texas Insurance Company is 123456.

TX 837 - Scenario 2

Texas Insurance Company
100 North River Drive
San Angelo, TX 75234

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 224-17-327

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Darlene Davidson

3. PATIENT'S BIRTH DATE MM DD YY: 06 04 69 SEX M [ ] F [x]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Bagels Etc.

5. PATIENT'S ADDRESS (No., Street): 5720 Green Drive

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [x]

7. INSURED'S ADDRESS (No., Street): 234 Main St.

CITY: Dallas STATE: TX

8. PATIENT STATUS: Single [x] Married [ ] Other [ ]

CITY: Dallas STATE: TX

ZIP CODE: 72309 TELEPHONE (Include Area Code): (214) 836-5527

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 72314 TELEPHONE (INCLUDE AREA CODE): (214) 472-1462

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 14007140

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [x]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [x] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME: 14007140

c. OTHER ACCIDENT? YES [ ] NO [x]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY: 09 18 02 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Lance Brown, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: DOG1023TX

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 814.2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 0011

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
08	27	03	08	27	03	22		64721		1	3250 00	2				
08	27	03	08	27	03	22		01810		1	5025 00	4				
08	27	03	08	27	03	22		94799		1	35 00	1				

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 34-5678912

26. PATIENT'S ACCOUNT NO.: 470077

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 8,310 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 8,310 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Gonzo's ASC
ASCTX 9/3/03
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Gonzo's ASC
16 Butterfly Lane
El Paso, TX 77702

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Gonzo's ASC
16 Butterfly Lane
El Paso, TX 77702
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500